payment is made under Medicare on a prospectively determined basis.

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions:

(1) Are needed immediately because of an injury or sudden illness.

(2) Are such that the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance and the nature of the medical condition.

Geographic area means the area found by HCFA to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means a Medicare beneficiary who has been identified on HCFA records as an enrollee of an HMO or CMP that has a contract with HCFA under section 1876 of the Act and subpart L of this part.

New Medicare enrollee means a Medicare beneficiary who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part; and

(2) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

Risk contract means a Medicare contract under which HCFA pays the HMO or CMP on a risk basis for Medicare covered services.

Risk HMO or CMP means an HMO or CMP that has in effect a risk contract with HCFA under section 1876 of the Act and subpart L of this part.

Urgently needed services means covered services that are needed by an enrollee who is temporarily absent from the HMO's or CMP's geographic area and that—

(1) Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and

(2) Cannot be delayed until the enrollee returns to the HMO's or CMP's geographic area.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 51986, Oct. 17, 1991; 58 FR 38072, July 15, 1993; 60 FR 45675, Sept. 1, 1995]

§ 417.402 Effective date of initial regulations.

The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

[58 FR 38072, July 15, 1993]

§ 417.404 General requirements.

(a) In order to contract with HCFA under the Medicare program, an entity must—

(1) Be determined by HCFA to be an HMO or CMP (in accordance with §§ 117.142 and 417.407, respectively); and

(2) Comply with the contract requirements set forth in subpart L of this part.

(b) HCFA enters into or renews a contract only if it determines that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

[60 FR 45675, Sept. 1, 1995]

§ 417.406 Application and determination.

(a) *Responsibility for making determinations.* HCFA is responsible for determining whether an entity meets the requirements to be an HMO or CMP.

(b) *Application requirements.* (1) The application requirements for HMOs are set forth in § 417.143.

(2) The requirements of § 417.143 also apply to CMPs except that there are no application fees.

(c) *Determination.* HCFA uses the procedures set forth in § 417.144(a) through (d) to determine whether an entity is an HMO or CMP.

(d) *Oversight of continuing compliance.* (1) HCFA oversees an entity's continued compliance with the requirements

for an HMO as defined in § 417.1 or for a CMP as set forth in § 417.407.

(2) If an entity no longer meets those requirements, HCFA terminates the contract of that entity in accordance with § 417.494.

[60 FR 45675, Sept. 1, 1995]

§ 417.407 Requirements for a Competitive Medical Plan (CMP).

(a) *General rule.* To qualify as a CMP, an entity must be organized under the laws of a State and must meet the requirements of paragraphs (b) through (f) of this section.

(b) *Required services.* (1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, the entity furnishes to its enrollees at least the following services:

(i) Physicians' services performed by physicians.

(ii) Laboratory, x-ray, emergency, and preventive services.

(iii) Out-of-area coverage.

(iv) Inpatient hospital services.

(2) Exception for Medicaid prepayment risk contracts. An entity that had, before 1970, a Medicaid prepayment risk contract that did not include provision of inpatient hospital services is not required to provide those services.

(c) *Compensation for services.* The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee.

(d) *Source of physicians' services.* The entity provides physicians' services primarily through—

(1) Physicians who are employees or partners of the entity; or

(2) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(e) *Assumption of financial risk.* The rules set forth in § 417.120(b) for HMOs apply also to CMPs except that reference to ''basic services'' must be read as reference to the required services listed in paragraph (b) of this section.

(f) *Protection of enrollees.* The entity provides adequately against the risk of insolvency by meeting the requirements of §§ 417.120(a) and 417.122 for protection of enrollees against loss of benefits and liability for payment of any fees that are the legal responsibility of the entity.

[60 FR 45675, Sept. 1, 1995]

§ 417.408 Contract application process.

(a) *Contents of application.* (1) The application for a contract must include supporting information in the form and detail required by HCFA. (2) Whenever feasible, HCFA exempts the HMO or CMP from resubmittal of information it has already submitted to HCFA in connection with a determination made under the provisions of § 417.406.

(b) *Approval of application.* (1) If HCFA approves the application, it gives written notice to the HMO or CMP, indicating that it meets the requirements for either a risk or reasonable cost contract or only for a reasonable cost contract.

(2) If the HMO or CMP is dissatisfied with a determination that it meets the requirements only for a reasonable cost contract, it may request reconsideration in accordance with the procedures specified in subpart R of this part.

(c) *Denial of application.* If HCFA denies the application, it gives written notice to the HMO or CMP indicating—

(1) That it does not meet the contract requirements under section 1876 of the Act;

(2) The reasons why the HMO or CMP does not meet the contract requirements; and

(3) The HMO's or CMP's right to request reconsideration in accordance with the procedures specified in subpart R of this part.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38078, July 15, 1993; 60 FR 45676, Sept. 1, 1995]

§ 417.410 Qualifying conditions: General rules.

(a) *Basic requirement.* In order to qualify for a contract with HCFA under this subpart, an HMO or CMP must demonstrate its ability to enroll Medicare beneficiaries and other individuals and groups and to deliver a specified comprehensive range of high quality